PRINTED: 05/04/2022
FORM APPROVED

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | **OPENING COMMENTS**<br><br>Rules and Regulations utilized for this survey are:<br><br>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.<br><br>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A licensure survey was conducted by Healthcare Licensing and Surveys from 4/18/22 through 4/20/22. Also reviewed in the course of the survey were complaint intakes LIC-22-012, LIC-22-013 and LIC-22-014.<br><br>Abbreviations used in this document:<br><br>CNA: Certified Nurse Aide<br>ADL: Activity of Daily Living | S 000 | | |
| S5002 | Ch 12 Sec 6 (c) Personnel and Staffing Requirements<br><br>(c) Background checks. All staff of the assisted living facility shall successfully complete, at minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of personnel records and staff interview the facility failed to ensure all staff completed a Department of Family Services Central Registry Screening before direct resident contact for 1 of 7 (#6) reviewed staff personnel files. The findings were: | S5002 | | |

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Quenzler
TITLE: Executive Director
(X6) DATE: 6/2/22



STATE FORM 6899 1XGF11

Approved: 6/15/22

James Thomas, RN
41190

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5002 | Continued From page 1<br>1. Review of the personnel files on 4/13/22 at 11:30 AM showed Department of Family Services Central Registry Screening had not been done for staff #6.<br>a. Review of the staffing records showed staff #6 had been on the work schedule since the hire date of 2/4/22.<br>b. Interview with the facility manager on 4/13/22 at 11:30 AM confirmed that the required screening had not been done for staff #6 before being scheduled for resident contact. She further stated that the screening should have been done. | S5002 | | |
| S5005 | Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services<br><br>(a) The assisted living facility core services include the following:<br><br>(i) Meals, housekeeping, personal and other laundry services;<br><br>(A) Provision of mechanically altered diets and dietary supplements, if required.<br><br>(ii) A safe and clean environment;<br><br>(iii) Assistance with local transportation;<br><br>(iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services;<br><br>(v) Assistance in adjusting to group living activities;<br><br>(vi) Maintenance of a personal fund account, if requested by the resident or resident's responsible party, showing any and all deposits, | S5005 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5005 | Continued From page 2<br>withdrawals, and transactions of the account;<br><br>(vii) Provision of appropriate recreational activities in/out of the assisted living facility;<br><br>(viii) Care of individuals who require any or all of the following services:<br><br>(A) Partial assistance with personal care, e.g. bathing, shampoos;<br><br>(B) Limited assistance with dressing;<br><br>(C) Minor non-sterile dressing changes;<br><br>(D) Stage I skin care - skin integrity intact;<br><br>(E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane;<br><br>(F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders to time, place and person;<br><br>(G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy;<br><br>(H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently;<br><br>(ix) Assessments completed by a Registered Nurse; | S5005 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5005 | Continued From page 3<br><br>(A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the residents' medication is changed;<br><br>(x) Twenty-four (24) hour monitoring of each resident.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of the Resident Guide (handbook) and resident, staff, and ombudsman interview, the facility failed to ensure resident's received assistance with local transportation for 3 of 11 (#7, #12, #13) residents reviewed for transportation needs. The findings were:<br><br>1. Review of the "Absaroka Senior Living Resident Guide" dated 2019 showed on page 18 under Life Enrichment Programs "To maintain contact with the community, you are encouraged to attend various senior citizen functions at the local Senior Center, community events, luncheons to local restaurants and other events as well as occasional outings." Further review showed on page 21 under Transportation "We have a passenger bus for your transportation convenience. There is no charge for scheduled Life Enrichment activities or transportation to medical appointments."<br><br>2. Interview with the regional Ombudsman at 9:02 AM on 4/19/22 revealed the Ombudsman had received multiple phone calls regarding the inability of residents to use facility transportation to have lunch with visitors of their choosing. The Ombudsman further stated she had visited the facility twice in the last month. | S5005 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5005 | Continued From page 4<br><br>3. Interviews with residents revealed they were unable to use the facility bus to travel to lunch. The following concerns were identified:<br>a. Interview on 4/19/22 at 12:55 PM with resident #7 revealed when the office found out several residents were having lunch with a discharged employee they quit letting them use the facility bus to go out to lunch. They were no longer able to use the bus unless the office approved where they were going for lunch and with whom. The resident further stated the use of the facility bus had been restricted for the last two months.<br>b. Interview on 4/19/22 at 1:15 PM with resident #13 revealed "I can't go where I want to and see who I want to."<br>c. Interview on 4/19/22 at 1:37 PM with resident #12 revealed "I am just plain mad. I have even talked to the corporate representative who was supposed to listen to complaints. We used to go out to lunch every other week and now we can't. I am told the bus driver just quit too."<br><br>4. Interview with the facility Administrator on 4/19/22 at 11:30 AM revealed the facility had experienced a lot of disruption since the former employee had been terminated, and had taken action to maintain facility security. | S5005 | | |
| S5020 | Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services<br><br>(e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. | S5020 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S6020 | Continued From page 5<br><br>(i) Each folder shall include the following:<br><br>(A) Information from the referring agent, if applicable;<br><br>(B) History and physical performed by a physician or physician extender;<br><br>(C) Individual admission form. This form shall, at a minimum, contain the following information:<br><br>(I) Full name of resident and former address;<br><br>(II) Date of admission;<br><br>(III) Sex, race, date of birth, social security number, and former occupation;<br><br>(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;<br><br>(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;<br><br>(VI) Medicare number or other medical insurance identifying data;<br><br>(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing;<br><br>(D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's | S5020 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5020 | Continued From page 6<br>family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records;<br><br>(E) An accounting of all personal funds deposited with and disbursed by the facility;<br><br>(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.<br><br>(1.) The facility must deposit any personal funds in the excess of $100 in an interest bearing account.<br><br>(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.<br><br>(3.) Upon the death of a resident with personal funds deposited with the facility, the facility must convey, within 30 days, the resident's funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. | S5020 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5020 | Continued From page 7<br><br>(4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid of Medicare except for applicable deductible and coinsurance amounts.<br><br>(F) A signed copy of the resident's rights;<br><br>(G) The resident's assessment and individualized assistance plan;<br><br>(H) Copies of al applicable resident assistance contracts, signed by both parties;<br><br>(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;<br><br>(J) Copy of all ALF 102's; and<br><br>(K) Copy of outside contractual responsibilities, if applicable.<br><br>(ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it.<br><br>(iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time.<br><br>(iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as | S5020 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5020 | Continued From page 8<br>to the location of all residents' records.<br><br>(v) All records shall be protected from damage by fire, water and other hazards.<br><br>(vi) All entries in each resident's record shall be made in ink, signed and dated.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on medical record review, staff interview, and policy review the facility failed to report all incidents as required for 2 of 4 residents (#1, #17) reviewed. The findings were:<br><br>1. Review of the medical record for resident #1 showed the resident had a fall in the shower on 3/5/21. Further review showed results for CT (computerized tomography) scan which indicated the resident had a non-displaced fracture through the anterior inferior iliac crest.<br><br>2. Review of the medical record for resident #7 showed the resident rolled out of bed on 11/18/21 which resulted in a femur fracture.<br><br>3. Interview with staff member #7 on 4/19/22 at 8:15 AM revealed there was no record of reported incidents, but "there had only been a couple."<br><br>4. Review of the facility policy titled "Incident reporting" dated 2020 showed "This community will report all accident, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation to the resident's family or responsible party and will document in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow-up | S5020 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5020 | Continued From page 9<br>and resolution." | S5020 | | |
| S5022 | Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services<br><br>(g) Grievance Procedure.<br><br>(i) The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints, and allegations of resident rights violations, and poor service provided to include, but not limited to:<br><br>(A) Resident's method to express and document grievances;<br><br>(B) Documentation of the provider's response to verbal and written resident grievances;<br><br>(C) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys); and<br><br>(D) The facility shall provide written reports of the grievances and resolutions to the Ombudsman and the Licensing Division within ten (10) days after the grievance is filed.<br><br>(ii) The written grievance procedure shall be posted in a conspicuous place within the facility.<br><br>This ELEMENT is not met as evidenced by:<br>Based on policy review and staff and resident interview, the facility failed to follow a written grievance procedure of documentation and | S5022 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5022 | Continued From page 10<br>reporting of all resident complaints for 7 of 11 (#6, #7, #9, #11, #12, #13, #14) residents reviewed for grievances. The findings were:<br><br>1. Review of the facility policy titled "Grievance Procedure policy" dated 2020 showed "Purpose: The purpose of this policy is to assure that employee and/or resident grievances and complaints are responded to timely and appropriately in a structure that encourages all to voice complaints and to seek their resolution." "Policy: All grievances and complaints will be reported, investigated, documented, and resolved." The following concerns were identified:<br>a. Interview on 4/19/22 at 12:55 PM with resident #7 revealed the facility would not allow residents use the facility bus for transportation to lunch with a former employee. The resident was told the former employee was terminated and was not allowed to enter facility property or communicate with residents. Further interview revealed the resident was told s/he did not have a complaint due to the former employee's termination status.<br>b. Interview on 4/19/22 at 1:15 PM with resident #13 revealed "I can't go where I want to and see who I want to. I have asked for help, but nobody cares."<br>c. Interview on 4/19/22 at 1:37 PM with resident #12 revealed "I am just plain mad." I have even talked to the corporate representative who was supposed to listen to complaints. We used to go out to lunch every other week and now we can't. I am told the bus driver just quit too."<br>d. Interview on 4/19/22 at 1:35 PM with resident #14 revealed "I'm afraid to say anything. Now we can't see [terminated employee]. We all really liked her".<br><br>2. Interview with the facility Administrator on | S5022 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5022 | Continued From page 11<br>4/19/22 at 11:30 AM revealed the facility had a lot of disruption since the employee had been terminated and had taken action to maintain facility security. Further interview revealed there was not a grievance log kept locally. | S5022 | | |
| S5041 | Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services<br><br>(l) Quality Improvement.<br><br>(i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services.<br><br>(A) A member of the facility's staff shall be designated to coordinate the quality improvement program.<br><br>(B) The quality improvement program shall encompass a review of all services and programs provided for all residents. the program shall have:<br><br>(I) A written description;<br><br>(II) Problem areas identified;<br><br>(III) Monitor identification;<br><br>(IV) Frequency of monitoring;<br><br>(V) A provision requiring the facility to complete annually a self-assessment survey of compliance with the regulations; and<br><br>(VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually. | S5041 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5041 | Continued From page 12<br><br>(C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions.<br><br>(D) The quality improvement program shall be re-evaluated at least annually.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on staff interview the facility failed to have a functioning quality improvement program and there had not been a meeting for over a year. The facility census was 41. The finding were:<br><br>1. Interview with the facility administrator on 4/20/22 at 11:10 AM revealed since the change in management organization the facility did not have a function quality improvement program and had not had a quality assurance meeting for over a year. | S5041 | | |
| S5047 | Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1<br><br>(a) The following services cannot be provided:<br><br>(i) Continuous assistance with transfer and mobility;<br><br>(ii) Care of the resident who is unable to feed himself independently and/or; monitoring of diet is required;<br><br>(iii) Total assistance with bathing and dressing; | S5047 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5047 | Continued From page 13<br><br>(iv) Invasive catheter or ostomy care, such as changing of catheter or irrigation of ostomy;<br><br>(v) Care of resident who is on continuous oxygen, if;<br><br>(A) Continuous monitoring is required; or<br><br>(B) Oxygen is ordered by the physician of physician extender to be titrated based on oxygen saturation levels;<br><br>(vi) Care of resident whose wandering jeopardizes the health and safety of the resident;<br><br>(vii) Incontinence care by facility staff;<br><br>(viii) Wound care requiring sterile dressing changes;<br><br>(ix) Stage II skin care and beyond;<br><br>(x) Care of the resident with inappropriate social behavior; e.g. frequent aggressive, abusive, or disruptive behavior; and<br><br>(xi) Care of resident demonstrating chemical abuse that puts him and/or other at risk;<br><br>(xii) Monitoring of acute medical conditions.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation, medical record review, and staff and resident interview, the facility failed to ensure residents were appropriate for the facility's level of care for 3 of 13 sample residents (#4, #5, #8) reviewed for appropriate level of care. The findings were: | S5047 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5047 | Continued From page 14<br><br>1. Observation on 4/18/22 at 11 AM showed residents #5 and #8 required assistance for any movement to and from their rooms. Both residents required assistance with ambulation and resident #8 required repeated direction to find his/her table or room. In addition, the room for resident #8 was the only door in the facility with the resident's name indicated on it.<br><br>2. Review of the medical records showed resident #4 had diagnoses which included cardiac arrhythmia with pacemaker, hypertension, osteoarthritis, and major recurrent depressive disorder. The following concerns were identified:<br>a. Review of a progress note dated 3/15/22 and timed 9:30 AM showed "Resident came down for breakfast this morning. [S/he] was able to ambulate independently. [S/he] doesn't remember falling last night or going to the ER."<br>b. Review of an "alert charting note" dated 3/12/22 and timed 9 AM showed "CNA alerted to side entrance door being open. [S/he] responded quickly to find that resident had eloped outside the building into the paved alley behind the building. [S/he] was able to reorient [resident] and get [resident] to come back towards the building. However, while [resident] was stepping up onto the curb from the pavement, [resident] mis-stepped and fell. Resident began bleeding from forehead above right eyebrow as well as from several spots on arms. [Resident] also broke glasses. CNA remained with resident while nurse went to call 911."<br>c. Review of a progress note dated 1/19/22 and timed 1:47 PM showed the resident reported that s/he was talking to his/her spouse who died years ago and the spouse was sitting in the room in the chair. | S5047 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5047 | Continued From page 15<br>3. Review of "resident concerns" in the medical record showed the following concerns for resident #8 were identified:<br>a. On 1/1/22 the resident was in another resident's room looking through the resident's personal belongings.<br>b. On 1/5/22 the resident awoke at 2 AM and was wandering in the hall and wanted to know where the cars were parked.<br>c. On 1/9/22 the resident entered another resident's room. The resident in the room said s/he was always trying to enter the room.<br>d. On 1/10/22 the resident was reported to be going in and out of other residents' rooms which resulted in other residents locking their doors.<br>e. On 2/26/22 the resident entered another resident's room and got in the bed.<br><br>4. Review of the medical records showed resident #5 had diagnoses which included Parkinson's disease, major depressive disorder and restless legs syndrome and the resident was on hospice care. The following concerns were identified:<br>a. Review of the "resident concern" dated 12/27/21 (no time indicated) showed "Resident extremely confused, asked how to go to the bathroom. Resident was incontinent and Resident not making any sense, complaining of itching and [his/her] mouth swollen shut."<br>b. Review of the "resident concern" dated 12/29/21 showed the resident was more confused and couldn't remember how to dress self, and continued to be incontinent.<br>c. Review of the "resident concern" dated 12/31/21 showed the resident came walking out of the dining room at 2:30 AM yelling "hello, help me" but didn't know what s/he needed help with.<br>d. Review of the progress notes for the resident dated 1/6/22 and timed 1:13 PM showed "Resident has been confused more lately than | S5047 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5047 | Continued From page 16 | S5047 | | |

usual, and has been having more incontinent episodes. Resident then today was trying to go out the front door and verbalized [s/he] was trying to escape, and that [s/he] thought people were trying to kill her."

e. Review of the progress note dated 1/30/22 and timed 7:10 AM showed "Was reported that resident was yelling this morning in [his/her] room, believing [s/he] was on a boat."

f. Review of the progress note dated 2/23/22 and timed 7:27 AM showed "Writer went to resident's room to administer pills this morning. Resident wasn't able to get out of recliner and had feeling of frustration."

g. Review of a resident concern note dated 2/23/22 showed staff #3 documented "Resident is pressing pendant for permission to use the restroom. Said [s/he] doesn't want to wear the briefs because [s/he] can't pull them up."

h. Review of progress notes dated 2/26/22 and timed 6:40 AM showed "CNA went into resident's room and found [her/him] sitting on the floor. Resident told CNA "I'm trying to get away from the ants so they don't get in by hair."

I. Review of the progress note dated 3/2/22 and timed 12:50 PM showed the resident fell on the floor in the dining room while attempting to get up. Further review showed it appeared the resident was leaning on one of the chairs when the chair slid out causing her/him to fall.

j. Review of the progress note dated 4/2/22 and timed 1:03 PM showed the resident was "uncooperative with staff today. Demanded the CNA put on her shoes. Resident proceeded to come out to the dining room with socks on and asked another resident to help put her shoes on. Once lunch was over the resident tried to climb under the table looking for their shoes which remained in the resident's room."

k. Review of the progress note dated 4/10/22

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5047 | Continued From page 17<br>and timed 9:05 PM showed "CNA reported that resident was using pendant to call for assistance frequently today needing help with most ADLs."<br><br>5. Interview on 4/20/22 at 9:18 AM with resident #6 revealed some residents take a lot of special care and need help just to go to the toilet. Others need to be helped out to every meal.<br><br>6. Interview on 4/20/22 at 11:20 AM with resident #11 revealed "I have to lock my doors just to keep people out who go in and don't even knock."<br><br>7. Interview on 4/20/22 at 12:55 PM with resident #7 revealed too many residents require help just getting to the dining room. Resident #8 must be helped all of the time because s/he doesn't remember the way. Further interview revealed s/he "certainly wanders all over and goes in everybody's room" and when the residents complained about the wandering they were told they needed to "show a little more compassion" and "just help them out of wrong rooms."<br><br>8. Interview with resident #11 on 4/19/22 at 1:57 PM revealed some residents wander at night and "I have to keep my door locked."<br><br>9. Interview with staff member #7 on 4/19/22 at 10:10 AM revealed the facility makes a special effort to provide extra care to those residents that need it. There were two residents that needed assistance to get out to every meal and one of them wanders occasionally. Further interview revealed resident #4 had to be transferred because they "got to where they were pretty much one-on-one care constantly." | S5047 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABSAROKA SENIOR LIVING | 2401 COUGAR AVENUE CODY, WY 82414 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5060 | Continued From page 18 | S5060 | | |
| S5060 | Ch 4 Sec 5 (j)(e) Licensure<br><br>(j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation and staff interview showed the facility failed to post the previous survey results in a manner conducive for public review. The census was 41. The findings were:<br><br>1. Observation of 4/18/22 showed the posting of the previous survey results was not readily available to residents, responsible individuals, or visitors.<br><br>2. Interview with the facility administrator on 4/20/22 at 11:30 AM revealed the results of the previous survey was kept locked in a credenza in the administrator's office. | S5060 | | |

**Absaroka Senior Living**
**Survey date: April 20th, 2022**

Tag S5002 June 2022

A) The community will ensure that all background checks will be completed before there is resident contact.
Once paperwork is completed and returned by candidate for hire, the Business Office Director will promptly submit paperwork to both the state of Wyoming Division of Criminal Investigation (DCI) and Department of Family Services for screening. Once completed without any deficiencies, candidate will be processed for hire.

B) Review of all new and current staff members will be reviewed for compliance and documentation for compliance.

C) A "New Hire check off list" is in place to assure everything has been completed before resident contact. Once completed, the list will be signed off by Business Office Director.

D) Depending on the number of new hires in a month, an audit will be done monthly by Executive Director and Business Office Director and will be documented and entered into the Quality Assurance Binder at quarterly meetings.

Tag S5005 04/18/2022

A) Executive Director completed and implemented with a clarification letter and a copy of the Resident Guidebook

which was distributed to residents and emailed to family members on the morning of April 18th in order to keep residents and family members informed of the procedures for **scheduled bus** transportation.

Evidence item 1 includes quotes from the Resident Guide, but not included in the Summary Statement is the following wording also in the paragraph referenced, "To maintain contact with community, you are encouraged to attend various senior citizen functions at the local Senior Center, community events, luncheons to local restaurants, and other events, as well as occasional outings. Absaroka provides **scheduled** transportation for many of these items at no additional charge for the event or if you require escort service that would be your responsibility to pay. We publish and distribute a Life Enrichment calendar each month that outlines upcoming events. Family members are also encouraged to participate in programs, social events, and excursions."

As noted in the Resident Guide "There is no charge for **SCHEDULED** transportation, but all appointments (outings) need to be communicated and logged in appointment book located in the Nurses station in advance."

As established in the Resident Guidebook as well as the letter sent to all residents on April 18th, transportation continues to be provided on **scheduled** days with prior

notification with the exception of emergency situations.

B) All residents will be provided a list of alternative transportation methods to include local Senior Bus transportation and cab services. This will be provided in with the "Move In" packet documents and addressed to any new residents.

C) To assure that residents understand policy and procedures on transportation, we will have the Maintenance Director and Transportation Driver address this in next Resident Council Meeting in June. Transportation policy & procedures for residents will be addressed to staff members at the next scheduled All Staff meeting.

D) To monitor that policy and procedures are being followed, Executive Director will check transportation schedule. Transportation Driver will log resident outings and documentation will be delivered to Maintenance Director. This will be added to the Quality Assurance Binder.

Tag S5020 06/2022

A) The Nursing staff will ensure to follow policy titled "Incident reporting" and to report to appropriate state entity through website portal or by making a phone call or sending a fax. Health & Wellness

Director will follow-up with a phone call to assure confirmation if done by website portal due to issues of reporting in the past.

B) A Fall Risk assessment that will be completed quarterly by using the Hendrich fall risk assessment to identify residents at risk.

C) Health & Wellness Director will report **daily** to Executive Director all incidents and to include those affecting the health, welfare of safety of a resident with documentation of reporting to the Licensing Division within one business day and to Long Term Care Ombudsman within 5 working days.
Will also educate clinical staff with in-service meeting on procedures for incident reporting.

D) The Executive Director will add to quarterly Quality Assurance meeting a section to ensure that all incidents affecting the health, welfare of safety of a resident have been documented and completed and placed in resident medical file.

Tag S5022 07/2022
A) All grievances will be notated in a Grievance Binder kept locally at community with follow up steps taken to address any resident concerns. The Binder will also contain policies, procedures, and forms. The Grievance Binder will be

available to all residents, families, and staff members upon request.
Binder completed 5/24/22

B) All residents are provided with a Grievance Policy and Procedures document along with a blank grievance form upon move in. Documentation is signed by resident or Resident Responsible Party along with Community representative acknowledging they read and understand how the Grievance Policy works. An audit will be performed of all current resident files to verify each resident received and signed policy documentations.

C) To assure that all residents understand the Grievance Policy and Procedures guidelines, a Community Representative will address these procedures at Resident Council meetings to ensure that they understand how to proceed in the event they have a grievance to report.

D) The Executive Director will add to quarterly Quality Assurance meeting a section to ensure that all grievances reported have been followed through and completed.

Tag S5041 07/2022
A) Community to hold quarterly Quality Assurance meetings with members from each department. Copy of Quality Improvement program available upon request to department. Executive Director

to be designated as quality improvement program coordinator, to identify any areas of improvement and resolution tracking.

B) Department managers will meet each quarter to discuss and identify department improvements or needs that ensure the best quality of life for our residents. Executive Director will execute the directive to each department to make sure all deficiencies from state survey audit are completed and in compliance to state regulations and bring documentation needed for Quality Assurance binder.

C) Department managers will complete a self-assessment survey at last quarterly meeting to make sure standards of compliance are being met.
A satisfaction survey will be provided to resident, resident's family and/or responsible party at annually.

D) Follow up with satisfaction survey to identify and implement any improvements that can be justified and put into place in a timely manner.

Tag S5047 06/2022
A) Community will continue to assess and document ongoing resident needs to ensure care needs are appropriate for community placement or transfers may be made to higher level of care. When needs exceed level of care provided at this venue, residents and family are given the choice to receive care from 3rd Party

Vendor at their own expense or receive a 30-day notice for transfer needed.

At this time resident #4, #5 and #8 have been discharged.
Resident #4 family had hired third-party caregivers to help until placement could be made. Resident #5 had help with family member, hired third party caregivers and hospice help until placement could be made. Resident #8 had third-party caregivers to help with cares and hospice to help with other needs until placement could be made.

B) The community will conduct quarterly assessments for each resident to begin 30 days after moving in or when there is change in resident condition or upon any significant change in resident's mental or physical condition. Once completed, the Health & Wellness Director and or/Executive Director will have a follow up meeting with resident and/or family members with any updates. Any changes will be documented and placed in resident medical records.

C) Health and Wellness Director will create and monitor a weekly spreadsheet to ensure the assessment paperwork is completed. Upon changes of condition, care plans will be updated and communicated to clinical staff. An In-Service meeting will be held with clinical team monthly to ensure that all residents are getting the cares needed and by

following the guidelines of the state requirements.

D) The Executive Director will add to the quarterly Quality Assurance meeting binder a section provided for the Health and Wellness Director to provide documentation of assessments completed and any necessary updates of resident concerns.

S5060 05/31/2022

A) Community shall maintain a copy of previous survey results in an area accessible to residents, responsible individuals, or visitors for review.

B) All residents will now have access to the State Survey results being in a public area that will also provide information of resident rights and the current information for the new Ombudsman, and Department of Family Servies. Residents will also be provided with this information at next resident council meeting.

C) To implement measures that show that community is complying, a weekly observation will be monitored to make sure Survey results are in place.

D) Executive Director will make sure that State Survey binder is in compliance by reporting at the Quality Assurance meeting and documenting that binder is where it belongs and available to the

public for review and/or to investigate if it becomes missing.